Recovery Kernel

DISCONTINUANCE PROTOCOL: OPIOIDS

Na wetin come after withdrawal be say e kill people.

Dis guide build around one difference wey must come first, cause if you reverse am, na wetin go cost life: opioid withdrawal itself, for most case, e no go kill you. E be one of di most physically miserable experience for all dis series, but e rarely fatal by itself. Wetin dey kill na wetin happen after — when body return to old dose by body wey don lose tolerance e get when dat dose feel normal. Dat single fact re-organize almost everything else for dis guide, and na why medication-assisted treatment (MAT) sit for center of e rather pass for corner.

Section 0 — Safety Wey You Must Read First

MEDICAL EMERGENCY

The high-risk moment for person wey dey recover from opioid no be withdrawal. E be relapse after long time wey dem don stop use. Person wey stop use na, if e return to dose wey e use before, e dey dose with tolerance of person wey never use opioids at all, while e expect effect like person wey use regularly. Dis one be the most common way say people die from opioid overdose, and e dey work pass for now because illicit supply don contaminate well-well with fentanyl — see Section 6.

Call 112 sharp sharp, and use Naloxone if you get am, for:

- Breathing wey slow, shallow, or don stop
- Blue or gray lips or fingertips
- No response or no fit to wake
- Sound wey dey gurgle ma so choke while you dey breathe

⚠ KAIUTION

Naloxone (Narcan) go reverse opioid overdose, and e no need prescription for most pharmacy for US, sometimes dem give free through harm reduction organization. Make e available — for yourself or anybody for your house wey get any history of use opioid, past or now — na say you no expect failure. E be same kind precaution like fire extinguisher: something you hope never need but still keep.

□ IBELE

Di physical symptoms of opioid withdrawal wey self — wey e talk for Section 2 — dem tough pass and genuinely vexing, but for most people wey no get other serious health

problem, dem no be thing wey go kill person by itself. Medical watch during withdrawal dey mainly to reduce suffering enough say person no go fall back into di danger wey I talk before, e no be say di withdrawal self typically need emergency help. Knowing dis difference no make process easy pass, but e change wetin you really fit fear, and when.

Section 1 — Why Dis Guide Center On MAT

Medication-assisted treatment — buprenorphine, methadone, or naltrexone — na, by plenty evidence wey dey, e be the one pass intervention wey sabi pass for opioid use disorder. Dis guide talk say direct and without any small talk, some recovery material still fit apply to am: MAT no be like say e weak form of recovery, e no be crutch, or 'still dey addicted to something.' E be life-saving medical thing with death reduction data behind am wey few other addiction treatment fit match. Recovery work wey go run alongside MAT — the biological, environmental, and identity work for Section 8 and 9 — na extra pass am, no be say e... alternative to am.

THE CENTURION

If dem tell you say na program or person talk say MAT mean say you no really sober, dat way of talking no get support from evidence abi e dey cost life. The thing wey matter na survival and how you dey function, no be whether specific molecules dey or no dey for person's body.

Section 2 — Di Time Wey You Go Pass Through Withdrawal

Time chart	Wetin dey happen?	Wetin you go expect	Wetin I do?
Hour 6-24 (start, e don vary based on how long opioid stay for body)	Opioid receptor occupancy don drop; di system leave without e expect input	Anxiety, body pain, sweat, yawn, runnin' nose, restless small small	MAT start, if dem decide do am, usually start for dis time frame — buprenorphine specially need say person dey light-light or medium withdrawal already before first dose make e no cause worse withdrawal.
Day 1-3 (wahala body plenty symptom)	Full withdrawal syndrome dey run strong; dis na passin hard physical wahala	Wahala stomach, vomit, loose stool, pain for belly, eye open wide, shivery come with	Medical supervision ma o MAT sharp reduce dis

Time chart	Wetin dey happen?	Wetin you go expect	Wetin I do?
		sweat, body ache like say you carry iron, no fit sleep	wahala. Dis be also high-risk time man wey dey think say e no fit survive, so e go return to use with dose wey don become dangerous — see Section 0.
Day 3-10 (after body calm down, mind plenty wahala)	Body withdraw resolve; endorphin and dopamine system for dem low low point	Deep deep sadness, no joy feel, emotion wey too raw, sleep still dey run wild, craving plenty time, small body pain still dey remain	Full supplement stack begin (Section 9). Do exercise as soon as body fit carry you, even small walk. Sleep manage na one of strong pass thing wey go help you avoid early relapse — make e your top priority.
Week 1-4	System endorphin and dopamine dey recover slow-slow; opioid receptor start to upregulate	Slow small better, but e go change every day; chance say you go get PAWS episode; mood dey shake pass; craving na thing wey strong die, but e no come everyday.	Full protocol dey run. Connection with community matter pass wetin e fit feel like e suppose do — isolation na one of strong pass predictor for relapse for dis kind recovery.
Month 1-6	Big increase for receptor; system wey dey control dopamine and endorphin dey rebuild well-well; pain sensitivity wey come from opioids (pain wey opioids self dey amplify) dey clear.	Progressive real improvement; genuine moment of natural pleasure return; pain feeling normal	Dis na where work go become steady pass just survive-survive. Identity work (Section 9) go fit here, no be before.
Months 6-18+	Density of mu-opioid receptor don recover well; endorphin system dey produce natural comfort and social bonding again	Natural joy and connect wey no need chemical support; PAWS episode dey rare; craving na context matter pass constant thing	Full endorphin system recovery for most people by 12-18 months of sustained recovery, whether

Time chart	Wetin dey happen?	Wetin you go expect	Wetin I do?
			that recovery include MAT or no.

Section 3 — Wetin Go Take Time Till Brain Don Return To Normal

Full mu-opioid receptor density recovery, for most people, take 12-18 months of sustained recovery — time wey match with the other long-recovery substances for this series. Post-acute withdrawal syndrome (PAWS) specifically fit run 18-24 months, and for fentanyl-involved recovery specially, that window fit run longer still, given say fentanyl get exceptional receptor-binding potency compared to other opioids.

Kedu be say you dey hear?

If you don dey eight months out still dey get PAWS waves — sudden anxiety, craving wey no get clear reason, days wey just flat like gray paint — na e no mean say work no dey do anything. E be exactly where honest timeline carry you go. Finish line for here na measure pass one year, and knowing dat before is meant to change how hard month eight feel, no mean make the hard month vanish.

Section 4 — Wetin You Go See Pass (Most Likely)

- One kind of deep feeling say everything no sweet for first few week — food, music, people wey you love dey feel like nothing special instead of sweet thing, cause e system wey endorphin and dopamine use before, na dem occupy by opioid, don reach true biological zero level.
- Amplified pain sensitivity (opioid-induced hyperalgesia) — na real thing wey dem document say your nervous system go become more sensitive to pain pass before you start use opioid, wetin e dey do as e dey re-calibrate. E go clear up for time wey dey Section 2 and Section 3, but while e dey happen, e go scatter mind.
- Sleep na thing wey e really hard to build back, sometimes na strong pass predictor say if person go relapse for beginning — e deserve treat am like any other part of dis recovery.
- Cravings wey fit come without say o clear reason, especially when PAWS wave dey blow — na matter brain science thing be dat, e no mean say you no serious about am.
- Pronounced feeling say you no connect with people or you lonely for dem wey carry G-allele OPRM1 specifically (Section 5) — the same receptor wey

dey control opioid reward also dey control endorphin-based social bonding, so when e low, e fit feel like isolation itself, no be just drug craving.

Section 5 — Gene Cross-Reference

Gene	Wetin e govern	Opioid Recovery Relevance
OPRM1 (A118G)	Mu-opioid receptor structure — na primary receptor wey all opioid dey work for	The single most important gene for all dis guide. Dem wey get G-allele, dem no sabi bind receptor well-well — e mean say dem get less pain relief and less reward from standard dose, which na part of wetin cause things scatter before. Dis same reduced binding also mean say dem get less endorphin-mediated reward from natural source (exercise, connection, laughter), which na why natural reward architecture fit take long time to feel satisfying for dis profile. Important thing: Dem wey get G-allele show strong response pass for naltrexone — dis direct actionable treatment-selection information wey you must carry go your prescriber.
CYP2D6	E dey change codeine, tramadol, and plenty other opioid pass to dem active or no-active form	Poor metabolizer no get much or no effect from codeine or tramadol, e don fit cause dem increase dose chasing effect wey that specific drug never go give am. Ultra-rapid metabolizer convert codeine to morphine fast pass — na documented way of die even with standard prescribed doses. E also affect buprenorphine metabolism direct relevant to MAT dosing.
CYP3A4	Primary metabolizer of fentanyl, oxycodone, methadone, and buprenorphine	The dominant pharmacokinetic gene for diopioids most people for recovery dey navigate, including both primary MAT medications. Inhibited CYP3A4 — from genetics or drug interactions (certain antibiotics, antifungals, even grapefruit) — fit cause dangerous build-up of these medications. CYP3A4 inducers fit make MAT withdrawal happen by clear the medication too fast. Tell every prescriber about every medication.
ABCB1 (P-glycoprotein)	Drug transport pass through blood-brain barrier	Variant dem dey change how much opioid fit cross inside brain from one dose wey give — some variant don make e enter CNS pass, e go give

Gene	Wetin e govern	Opioid Recovery Relevance
		strong effect from same dose na, and e fit speed up development of dependence. E also affect buprenorphine and methadone CNS concentration, e important for optimize MAT.
DRD2 (Taq1A, A1 allele)	Dopamine DRD2 receptor density	Kedu be say receptor density for A1 carriers don fall down like 30% — Na Reward Deficiency Syndrome. When e mix with OPRM1 G-allele, e go create compound reward-system deficit wey dey affect both opioid and dopamine reward pathways at the same time — na one of di high-complexity profile for dis series.
COMT	Dopamine clear up and how body dey process pain signal	E relevant pass for anybody wey ginger use opioid start from pain medicine true true — COMT variants dey change how body feel pain before any opioid come, e mean say pain wey no get proper treat fit still need own special way to manage (Section 6) even when dem don sort out the opioid dependence itself.
MTHFR	Methylation — how dem build neurotransmitters	Low baseline dopamine and serotonin synthesis wey opioid fit dey compensate small small. Support with 5-MTHF na foundation, e no be option, for dis recovery.
GABRA2	GABA-A receptor alpha-2 subunit — low level of stopping action	No be primary opioid gene, but e be real compounding factor, for two reason: na same GABA architecture wey dey run background to common opioid-plus-benzodiazepine or opioid-plus-alcohol co-use pattern (each substance dey target different receptor system for related anxiety/inhibition problem), and e dey drive the specific combined profile wey I show below.

How COMT Status Change Wetin Opioids Really Feel Like

COMT control how fast dopamine and stress chemical pass out, and dat passing out speed shape wetin opioids dey do for one person—no be just how much dem use, but why di feeling sweet enough to make e seem necessary from start.

COMT Profile	Baseline Kedu Opioids	Wetin kind Opioids dem give?
Val/Val ('Warrior')	Sometimes e dey dull when	Opioids give kind of relief wey

COMT Profile	Baseline Kedu Opioids	Wetin kind Opioids dem give?
— clear pass quick, low down dopamine tone	e no do anything; e like things wey strong and new, even if nothing real dey inside.	different from other profiles — no be 'finally, quiet' pass, na more like 'finally, comfortable enough to stop chasing intensity.' Dis profile e dey small small common for pure opioid dependence pass for stimulant dependence, but when e show up, recovery need real high-intensity outlets, no just calm-focused work.
Met/Met ('Worrier' / 'Sage') — slow clear, high background stress-chemical vibe	E choke time, dey restless or too much energy when e no do anything; body's nerves dey run hot even before person use anything.	Dis na im common opioid-recovery profile. Opioids' HPA-axis suppression (genetic table for Section 5) direct answer one system wey dey stress pass normal — e no be just physical comfort, na first time one already hot nervous system get chance to fully calm down. Dis na also the profile where the HPA-axis rebound wey talk elsewhere for dis guide go hit hardest, cause there plenty baseline stress-chemical activity to bounce back into overdrive.
Heterozygous (Val/Met)	One level wey dey middle of the two profile diji.	Sometimes na mix — some be true body pain wey dem wan escape, some be stress system relief wey dem wan find — no be say e too much like homozygous profile pass.

GABRA2 and 'Anxious Depressant Pattern'

Dis one worth name direct rather than leave GABRA2 as small footnote for table above. Your Compendium's own Gene-Substance Matrix detect specific combined profile — GABRA2 high-risk plus COMT Met/Met — as 'Anxious Depressant Pattern,' relevant cross alcohol, benzodiazepines, and opioids: compromised self-soothing capacity (COMT) stack on compromised inhibitory tone (GABRA2), make pass fastest documented progress to dependence of any combined profile for that matrix.

⚠ KAIUTION

If dis combination dey apply to you, two things na important make you know clear. First, e part of why people use many drugs—opioids plus benzodiazepine or alcohol—na common pattern for this kind profile: the opioid dey answer the stress-system and pain-relief side, while the GABA-targeting substance dey separately answer the underpowered-brakes side, and neither one fully cover wetin the other dey do. Second, e mean say recovery for this profile really need both systems address together—the opioid-focused work for dis guide, and the GABA-focused work for di Recovery Kernel's Benzodiazepine or Alcohol guides if either substance e sin part of pattern too — instead of treat opioid dependence like say na whole story.

Phenotyping Without Test Result

- Opioids don give you pain relief wetin other thing no fit, even when dose others people find plenty? → Possible OPRM1 G-allele or ABCB1 variant. CYP2D6 testing na one wey e good to prioritize.
- Opioids don give you feel like normal, connect, and easy for anything else no fit do? → Strong OPRM1 involvement and e shock say body dey lack endorphin system. Work on social bond (Section 9) na main thing, e no be extra thing, to your recovery.
- Your use start with legit pain treat? → COMT pain-sensitivity variants fit come play. Pain wey no get enough treat need own separate treat path — see Section 6.
- Na baseline emptiness pa anhedonia be wetin dey follow you always, no matter if you dey use opioid abi? → Likely DRD2 deficit plus MTHFR involvement. Dopamine support na high priority.

Section 6 — Special Population

Situation	Wetin make am different?
Chronic pain make e be entry point	For big portion people wey dey opioid recovery, real chronic pain na original thing and e still remain real, ongoing condition. Knowing say you get genetic weakness wey cause dependency no mean say pain itself never real, and e no go disappear when opioid don pass. Dis group need pain management track run alongside recovery track — e no mean say e replace am — physical therapy, non-opioid pain management, and for some case buprenorphine specifically prescribe for pain (na legitimate, different use case from its role for MAT for dependency) indefinitely with recovery work. Pain wey no get manage na one of the most predictable pathway ji go back to opioid use of anything for dis guide.
Supply wey get fentanyl contamination	Dis current illicit opioid and, increasingly, illicit stimulant and counterfeit pill supply don plenty contamination with fentanyl, e be like say na thing wey pass heroin or prescription opioids by weight. Person wey get tolerance build on heroin or pills no get reliable protection against batch contaminated with fentanyl — di potency difference fit kill person for dose wey go sweet small small with substance dem think say dem dey use. Fentanyl test strips (dey available through most harm reduction organizations) and naloxone access no be optional precaution for anybody wey dey use opioid now — na baseline safety equipment, same category like Section 0's fire-extinguisher framing.
For IV/injection route specifically	E carry extra risk wey dey write for Recovery Kernel's Ears, Eyes, and Teeth guide — infection at injection site, endocarditis, hepatitis C and B, and HIV. Bloodborne infection testing when you start recovery na proper medical care, e no be accusation — and modern hepatitis C treatment fit cure person for plenty case, no matter how long the infection don dey.

The Substitution and Taper Landscape

For anybody wey dey reduce prescription opioid pass, di substance itself go change how di taper go look. Dis na general overview, no be individual dosing schedule — di exact numbers need doctor wey sabi person wey dey take dose, current dose, and time. Wetin follow na framework wey you fit carry go talk with am.

Substance	Wetin make e complex to taper?	General way o
Fentanyl (patch or illicit)	High power mean say even small percent drop show big change for actual amount; e patch wey dey stick to skin add another kind variation for how e enter body (heat, skin matter, and where you put patch all fit change how e reach) on top of wetin science talk about.	Patch taper na normal move go next-low patch strength on long time interval (usually every 2-4 weeks, follow same percentage-based principle use throughout this library), sometimes with mouth medicine bridge for gap between patch strengths. Illicit fentanyl tapering no easy do as direct patch-to-patch reduction — e usually need make person convert to measurable, prescribable form first (see MAT, Section 8).
Oxycodone ER (OxyContin) na other extended-release oral opioids	Dis extended-release mechanism mean say dose reduction change both the peak effect and the time wey e go cover you — one cut wey look small for paper fit give coverage gap wey feel like too big.	Slowly reduce di dose wey dem give you for long time, usually 10-25% every 1-4 weeks depending on how long you use am and how bad e be, sometimes dem get small dose one wey fit help when you dey pass from one to another — na decision for the doctor wey write prescription, no be say you decide by yourself.
Hydromorphone (Dilaudid)	Short half-life na wetin make e potent pass morphine, meaning withdrawal go start fast and concentrate pass say long-acting opioid do, kedu like shape wey dem show for short-half-life wahala wey dem talk about venlafaxine for SSRI/SNRI guide.	E don common pass (rotate) give long-lasting opioid first specially make the taper itself easy to manage, instead of just taper di short-lasting one direct — dis change na real clinic way, no be work around, and e must be doctor wey go manage am because of di potency math wey dey inside.
Tapentadol (Nucynta)	One kind of mechanism wey different from others for dis table — e be dual action as both mu-opioid agonist and norepinephrine reuptake inhibitor. Dis second mechanism mean say some people no fit take am well-well because	If tapentadol no dey sweet to body, na real good info for doctor wey dey prescribe — e fit show say problem no be because of opioid dosage alone, but e fit point to dual mechanism pass, and make person choose totally different medicine instead of just change dose of same

Substance	Wetin make e complex to taper?	General way o
	reason wey no relate with opioid receptor sensitivity: added norepinephrine activity fit cause anxiety, jitteriness, or heart rate too high, especially for anybody wey already dey run high-arousal baseline (the COMT Met/Met profile for Section 5's table na thing wey you need consider here specifically).	one.

Pharma's Opioid-Sparing Substitute: Gabapentin and Pregabalin

One common way we dey prescribe medicine deserve same direct treatment say this library already give am for other place: gabapentin and pregabalin na things dem frequently offer specifically to avoid prescribing opioid, or to support opioid taper by cover some of the nerve-pain part. Dis fit be legitimate, useful tool. E fit also become its own unaccountable, indefinite prescription if nobody dey track exit date.

⚠ KAIUTION

The Recovery Kernel's own material on gabapentinoids dey apply direct here: dem dey increasingly recognize say dem carry real dependence and withdrawal risk of their own, including seizure risk at high doses if you stop am sudden, even though before dem prescribe am like say e no get risk. If dem give gabapentin or pregabalin as alternative to opioid, same accountability question from this library's Section on substitute medications dey apply: wetin be stated exit date or review point, na time-limited bridge be dis or open-ended maintenance, and how go look tapering dis specific medication if e need to end. Medication wey avoid one dependence risk no mean say e no get dependency risk by itself.

Address Root Cause, No Be Just Taper

For di significant population for Section 6 wey opioid use start with real pain, di taper itself na necessary but e no complete — according to Section 1 and Section 6's way of talk, unmanage pain na one of di most predictable road back to opioid use of anything for dis whole guide. To solve wetin the pain really be, and treat am straight, no be just extra nice-to-have thing. E be mandatory part of make di taper stand strong.

- Real pain-source evaluation — imaging, specialist referral, or any diagnostic step wey no happen yet — instead of just continue treat the symptom forever.
- Physical therapy na wetin go help with pain, plus no-opioid drug treatment, wey pain specialist go manage with the doctor wey dey reduce dose.

- Ketamine infusion therapy — na real, established option for certain refractory chronic pain conditions (complex regional pain syndrome, fibromyalgia, and some forms of neuropathic pain), wey dem dey give as sub-anesthetic infusion for monitored clinical setting, different from the discontinuation-support framing dem give wetin dey elsewhere for this series. E good to raise direct with pain specialist if standard non-opioid options no sabi pass.

SANCTUARY

If nobody don really diagnose wetin dey pain—only ever treat say e dey—na thing wey you need talk clear-clear to doctor. To reduce medication wey dey manage unknown problem, without also follow up wetin be actual problem, na exactly the situation dis guide dey try help make you avoid.

Section 7 — Use Pattern Classification

Level	Pattern	Danger	Stance
1 — For prescription, small time, no increase	Legitimate prescription wey dem give you make you use am like say dem tell you, for small time only.	Low low, but no zero — body dey depend on substance fit start for week 1-2 after regularly use even if e no be misuse	Planned taper with doctor wey prescribe, instead of sudden stop, e still be safest option even for dis level.
2 — Wetin dem prescribe, long time, or small increase	Use pass time wey dem prescribe originally, or increase dose small small make e remain same effect	Moderate — body don sabi am well-well	Supervised taper e dey important here; sudden stop fit cause heavy withdrawal, and dis na kind people wey say talk small small about MAT, even if e no last long, e sweet make we do am for front.
3 — Use wey no come from doctor, or e don scatter pass normal level	Use pass wetin doctor give you, use medicine wey no belong to you, or use drug wey no be for every day dose time.	High	Na so e be say make you take medical help strong-strong before you try anything to stop. MAT no fit just be small thing for talk wey you dey do; e must be proper part of dis conversation, e no fit be only last option.
4 — Depend, every day use include make e no happen	Every day or almost every day use, including use specially to stop withdrawal signs instead of for feeling	Severe — dis na say population Section 8's MAT and detox	No be say you fit stop am without supervision. Warning relapce-overdose for

Level	Pattern	Danger	Stance
withdrawal		protocol write for	Section 0 dey apply strong-strong to people wey get dem.

Section 8 — Treatment With Medicine and Detox

Oga/Madam, medicine	How e work?	Clinical Notes
Buprenorphine (Suboxone, Subutex, Sublocade)	Partial opioid agonist — e go activate receptor pass enough make dem no feel withdrawal and craving, with ceiling effect wey go limit chance of overdose compare to full agonists	E need make person don dey mild-to-moderate withdrawal sharp before dem take first dose (make e no happen sudden withdrawal). E fit give for office setting by trained people, e go improve access pass compare to methadone wey dey clinic only.
Methadone	Full opioid agonist, long-acting — e stabilize receptor activity without the peaks and troughs of shorter-acting opioids	E need dose every day for licensed opioid treatment program for most case, at least first time. Plenty strong proof, especially if dependency heavy pass or long time. Status na CYP3A4 (Section 5) e dey affect how you go dose.
Naltrexone (for mouth or long-lasting Vivitrol)	Opioid receptor antagonist — e block the receptor completely instead of make am work, e no give any opioid effect and e go block any effect from any opioid wey dem use on top of am.	E need full detox (usually 7-10 days no opioid) before you start, because e go cause heavy withdrawal if opioid still dey for body. Dem wey get OPRM1 G-allele carriers (Section 5) show strong response pass — really useful, actionable info make you select treatment.

THE CENTURION

Mat selection na real clinical decision wey dey benefit direct from genetic info for Section 5 — carry am go show person wey dey manage dis thing with you.

Section 9 — The Recovery Protocol

Tier 1 — Biological Foundation (From Day 1 till)

Support	Role
DLPA (DL-Phenylalanine)	Support precursor for endorphin system — start Day 1 if you dey chop.
NAC (600mg twice daily)	Glutamate homeostasis na wetin dey help reduce craving.
5-MTHF	Support for foundational methylation and neurotransmitter

Support	Role
	making.
Magnesium glycinate	Support general nervous system and sleep.
Omega-3 (EPA-dominant)	General neurological support while body dey rebuild pass.

Tier 2 — Medical

- MAT for Section 8, as na main medical thing wey dey use, no be just small support.
- Pain management track (Section 6) run for side if e dey pain pass—dis no be option for dat people.
- Testing and treat bloodborne infection if e dose inject before (Section 6).

Low-Cost Practical Tool: Time-Locked Dispensing

E good to mention direct because e cheap, really useful, and no dey talk about am plenty for recovery material: na kind safe wey dey lock medicine with time, specially for situation like taper, where goal na controlled, scheduled access rather than either full self-access or no access at all. One person wey you trust — partner, family member, or other overseer — go load the doses according to the taper schedule wey dem set with the doctor wey prescribe am, and the device physically no go open till the time wey e schedule, no matter how person dey feel for moment. Dis directly address same access-and-friction mechanism wey dem talk about elsewhere for dis library no dey continue series: removal of power to do wetin your mind tell you make you take dose before time or extra dose na self real, body support, e no be just say talk.

⚠ KAIUTION

Standard warning dey apply, and dem matter: dis na support tool, e no be substitute for di medical taper plan itself, and e no be substitute for MAT or doctor supervision where dem show say e need. E require one overseer wey you sabi trust well-well, wey go dey consistently available — di tool no go work if person wey control am no reliable, and e fit turn come source of fight or vexation if man introduce am without honest talk about why. E no stop anybody from get medication or substance outside di device entirely, so e address one specific risk (impulsive early redosing of di tapering medication) rather than The full picture. Most model get kind emergency override—know wetin dat be and who control am before you rely on device. And e no fit be only safety measure for anybody wey dey higher-risk classifications for Section 7—e na practical support alongside medical care, no be replacement for am.

On Substance Wey No Come From Proper Place: Why 'Just Trying To Survive Till The Money Run Out' Na E Own Danger

Dis one deserve direct, serious treatin', e no be small talk, 'cause di risk na different kind from anything else for dis guide. Medication wey come from licensed pharmacy get documented chain of custody — dem manufacture am under

regulated condition, verify dose and composition, fit trace every step from production till the bottle hand. Substance wey you get outside dat system, e no get any of dis. No paperwork, no certification say where e come, no check if wetin dey inside am, no way to know wetin e pass through or dem mix am with before reach person wey go use am. Dis no be... Moral judgement about the choice wey you wan follow am — na physical truth about di thing wey matter, no matter why person wan get am.

MEDICAL EMERGENCY

Dis no be abstract risk. For Section 6, na say current illicit opioid supply — and increasingly di illicit and counterfeit pill supply generally — don plenty contamination with fentanyl, e be potent enough by weight say fatal dose fit dey without any visible, tastable, or detectable difference from one wey no contaminated. Person wey dey bridge gap during taper, or wan find relief from withdrawal symptoms outside medical channels, by use whatever dey available for street or from unverified source, e no be make same kind decision like person wey dey continue supervised medication. E be decision wey don make with zero information about wetin dey take. Fentanyl test strips na so e reduce but no mean say e clear — the only way to fully avoid am na make you no use unverified source at all, which na exactly why di medical and MAT pathways for Section 8 exist as the recommended route through a taper, difficult how dat route fit be to access.

Tier 3 — Nervous System and Endorphin Architecture (Month 1-12, na time wey dey center)

- Every day strong exercise — na main way to get endorphins wey no need medicine, and e be the one thing dem consistently talk for every guide for dis series.
- Real community and connect—e no be by chance, but e dey structure, given how direct say opioid receptor system dey control social bonding reward (Section 5).
- Cold expose, laugh, and music — each get real, if small, effect wey dey make endorphins work, e good to stack dem together.

IBELE

Endorphin architecture go build back through steady daily work for month, no be say you do am once-time. Dis no be say I dey criticize anybody wey struggle make e last — na true shape of wetin dis recovery need pass, match to true time wey dey Section 3.

New Thing Wey Dey Come Out: Oxytocin and the HPA-Axis Reset

Section dis dey here because your own Main Book give full chapter talk about am, e deserve proper place for here pass say make we leave am out. Mechanism e talk about na real thing and already name am elsewhere for this guide: opioids suppress HPA axis for as long as dem use am, and when dem remove am, that

suppressed system no return soft-soft to normal level — e rebound, often plenty pass normal. Cortisol flood, amygdala run hot, and nervous system report say na existential emergency with no outside cause. Dis be the body reason why opioid withdrawal fit feel like die even when e no be say na danger to body (Section 0) — di feeling wey you get na true talk from stress system wey don run pass level, e no be say na nonsense reaction.

⚠ KAIUTION

Oxytocin na direct antagonist to cortisol-releasing cascade — e dey shut down HPA axis, e function like true off-switch for alarm system opioids don keep quiet. Your own source material clear and worth repeat with same honesty: dis protocol na experimental, no be FDA-approved for addiction treatment, and currently use by only small number of forward-thinking clinics and informed people working at edge of recovery science. E belong for this guide as documented, real mechanism wey worth know exist — no be like self-directed intervention. Any person thinking about am should do am with psychiatrist or doctor wey sabi addiction medicine dey follow close, same standard say dis series don hold for every other Emerging-tier addition.

By practical way, dis one be same kind addition like di intranasal oxytocin material wey don write for Recovery Kernel's discontinuance series for benzodiazepine withdrawal — e mechanism (HPA-axis dampening) na same, and caution wey sabi pass: real thing, worth talk with specialist, no be standard-of-care tool yet.

Section 10 — Recognize Danger Again

MEDICAL EMERGENCY

CALL 112 AND USE NALOXONE IF AVAILABLE FOR: slow, shallow, or stopped breathing — blue or gray lips or fingertips — unresponsiveness — gurgling or choking sounds. Dis one dey strong pass after any time person stop use or leave substance, because of the lost-tolerance mechanism for Section 0, and with fentanyl contamination (Section 6) as extra, unpredictable risk layer on any opioid wey come from illegal source.

Section 11 — Full Protocol Cross-Reference Map

Reference	Wetin e give
Recovery Kernel Opioid Guide, Section 3	Di whole MAT and detox framework, dis guide's Section 8 dey summarize am.
Recovery Kernel Fentanyl Guide	Detail wey concern contamination for Section 6 — testing strip, na Naloxone access, and di specific pharmacokinetics of fentanyl compared to other opioid.
Recovery Kernel Ears, Eyes, and Teeth Guide, Section 5	Full detail on infection risk wey come from injection, like say e dey mention for Section 6.
Compendium Protocol 14 (Management Pain)	Di parallel pain-management track wey dem mention for Section 6, na e be for anybody wey i start use opioid

Reference	Wetin e give
	because of real pain.
Compendium Protocol 05 (Redesign Environment)	Protocol wey pass top for dis kind recovery na say craving wey come from trigger na main way person fit fall back into use when e dey recover from opioid, pass wetin happen with most substance for series dis.
Compendium Gene-Substance Matrix, Appendix A	The direct protocol-code mapping behind Section 5's genetics: GABRA2 + COMT Met/Met ('Anxious Depressant Pattern') map to P06, P09, P10, P21; GABRA2 alone map to P01, P06, P20; GABRA2 + MTHFR ('Depleted-Impulsive Pattern') map to P06, P07, P11, P21. Cross-reference dis appendix direct if you get full genomic panel.
Recovery Kernel Main Book, Section 8 (Oxytocin Protocol)	Di whole source chapter wey dey behind Section 9's Emerging Addition — complete mechanism detail, and di same experimental-use caveats repeat for dis guide.
Compendium Protocol 20, 21, C-28 (Identity Architecture)	Shine proper start for Month 1-6 (Section 2), no be before — rebuild identity wey no dey follow use history.
Recovery Kernel Complex Trauma and the Substance Connection	Opioid use disorder na time wey e usually start for time say life tough pass; work wey focus on trauma no fit start till body and MAT stable—time matter pass anywhere for dis series.

Section 12 — Closing

SANCTUARY

Opioid recovery na one small area for addiction medicine wey get strong evidence base behind e best treatment — MAT dey save life, repeatedly, clear clear. Use am no mean say e be lesser form of recovery. The endorphin and receptor system wey opioids occupy fit build back, on real timeline, whether or not that recovery include ongoing medication. Wetin matter pass, for Section 0, na surviving the window where tolerance and expectation scatter — everything else for this guide dey exist to carry you safely past that point.

END OF GUIDE — DISCONTINUANCE PROTOCOL: OPIOIDS

Harm Reduction Resource — E no be Medical Advice — E no be Replacement for Emergency Care

Crisis Resources: 988 (Suicide & Crisis Lifeline, call or text) | SAMHSA: 1-800-662-4357